STATE EMPLOYEES WORKERS' COMPENSATION
One Capitol Hill
Providence, RI 02908

24 HOUR NOTIFICATION OF INCIDENT/INJURY
(To be Completed by Supervisor)

Name: _____ **Occupation:** _____

Phone #: _____

Agency: _____ **Payroll Account#:** _____

Injury Date: _____ **Incapacity Date:** _____

Time: _____ AM/PM **RTW:** _____

Location of Incident: _____

Body Part Injured: _____

Description of Incident: _____

_____

_____

_____

Date Employer Notified: _____

Supervisor's Comments: _____

_____

_____

Employee's Physician: _____ **Witness:** _____

Phone #: _____ **Phone #:** _____

Supervisor: _____

Phone #: _____

In order to expedite the processing of a claim it is important that this form be forwarded to your Human Resource Office promptly. Any questions please call your Human Resource Office at 222-2572 (extensions 4612, 4613, or 4614).